luminare health℠

COMMUTER BENEFITS

FLEXIBLE SPENDING ACCOUNT
REIMBURSEMENT REQUEST FORM

Phone: 1-877-267-3359 **SEE REVERSE SIDE FOR INSTRUCTIONS** **Fax: 1-866-514-8287**

A. EMPLOYEE INFORMATION

Name	Social Security Number (last 4 digits)	Name of Employer
Member ID	**Phone Number**	**Email Address**

B. COMMUTER BENEFITS PARKING ACCOUNT

Date(s) of Service	Name of Parking Facility	Claimant Name	If documentation is not available, explain why it is not provided by the parking facility. *(For example, metered street parking does not provide a receipt.)*	Amount Requested
			TOTAL AMOUNT REQUESTED	$

C. COMMUTER BENEFITS TRANSPORTATION ACCOUNT

Date(s) of Service	Name of Transit Authority	Claimant Name	If documentation is not available, explain why it is not provided by the parking facility. *(For example, metered street parking does not provide a receipt.)*	Amount Requested
			TOTAL AMOUNT REQUESTED	$

D. CERTIFICATION

I certify that the following is true:

1. The expenses listed above were incurred by me and qualify for reimbursement within the current plan year.
2. You have incurred the listed expenses. Note: parking expenses require a receipt or other proof, unless employees park in a metered lot where receipts are not available. Even in the absence of receipts, by claiming reimbursement you are attesting that the expense actually incurred.
3. You are not being reimbursed for these expenses from any other source.
4. You assume all responsibility for taxes or penalties arising out of disallowed deductions.

Employee Signature	Date

Submit claim(s) electronically at myluminarehealth.com

Or return this form to:
Attn: Benefits Spending Accounts
P. O. Box 2968
Clinton, IA 52733
Phone: 877-267-3359
Fax: 866-514-8287
Email address:FlexHB@luminarehealth.com

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